



PROCEDURAL SEDATION/ANALGESIA RECORD

Pre-Procedure (Service): Date 1/28/21 Time 1027 Procedure: COLONOSCOPY
 Reason for Visit: ROUTINE SCREENING
 Last solid food intake (date / time) 1/27/21 Egg white Bread & 600 Last fluid intake (date / time) 1/28/21 0800
 Type of Prep: Dulcolax / Miralax Gatorade -> Brown-Watery
 Name of responsible adult who will accompany you home: Self-No Drive Waiting Room Phone # _____
 May discuss medical treatment May **NOT** discuss medical treatment
 Routine Medications See MAR See Medication Reconciliation Form AMPICILLIN, HCTZ, LATEX
 Allergies Reviewed Bracelet Applied
 SEE UNIT SPECIFIC RECORD REVIEWED PATIENT H&P/DIAGNOSTIC TESTING (within 30 days of procedure)
 Previous Surgeries 1994 Lipoma 2018 left Shoulder Rotator cuff See H&P
 Implants _____ See H&P

Nursing Pre-Procedure (Service) Assessment and Care Plan See EMR

Psychosocial Assessment	Yes	No	Teaching Plan	Yes	No	Personal History	Yes	No
Have you or any blood relative had any complications to sedation/Anesthesia? Explain: _____		<input checked="" type="checkbox"/>	Patient / Family verbalized understanding of teaching and procedure/sedation.	<input checked="" type="checkbox"/>		Caffeine Use	<input checked="" type="checkbox"/>	
Addictive Behavior?	<input checked="" type="checkbox"/>		Pain Scale reviewed, patient expresses understanding of 0 - 10 pain scale.	<input checked="" type="checkbox"/>		Sedative Use		<input checked="" type="checkbox"/>
Do you smoke? Smoking cessation provided <input type="checkbox"/>	<input checked="" type="checkbox"/>		Discharge expectations discussed with patient.	<input checked="" type="checkbox"/>		Body Piercing	<input checked="" type="checkbox"/>	
If yes, amount: Quit? When: <u>Vape</u>			Permission to make follow up call or leave message. Number to call: _____	<input checked="" type="checkbox"/>		Location: <u>jaw</u>		
Have you had an unintentional weight loss > 10 pounds in 6 months? See Nursing Notes		<input checked="" type="checkbox"/>	Barriers to Learning? If yes, explain: _____		<input checked="" type="checkbox"/>	Drug Use <u>Canabys</u>	<input checked="" type="checkbox"/>	
Do you feel emotionally and physically safe? Resources provided <input type="checkbox"/>	<input checked="" type="checkbox"/>		Interpreter present? _____		<input checked="" type="checkbox"/>	Alcohol?	<input checked="" type="checkbox"/>	
Spiritual/Cultural needs? (If yes, enter Chaplain consult) Or restrictions? What: _____		<input checked="" type="checkbox"/>	PERSONAL ITEMS			If Yes, Amount: <u>occ</u>		
			<input type="checkbox"/> Dentures <input type="checkbox"/> Glasses / Contacts			Advanced Directives Present? Resources Provided		<input checked="" type="checkbox"/>
			<input type="checkbox"/> Hearing Aids <input type="checkbox"/> Other: _____			DNR		<input checked="" type="checkbox"/>

Pre-Procedure (service) Assessment: The following assessment is needed just prior to all invasive procedures using moderate sedation Check all that apply.

Vital Signs: Time 1050 Ht. 67" Wt. 185# BMI 29.0 Blood Glucose NA Temp. 99.0
 BP 127/93 Pulse 73 Respirations 17 SaO2 97 % Room air O2 _____

Neuro: oriented & converses disoriented & converses inappropriate words incomprehensible sounds
 unconscious calm apprehensive agitated Other 4/0 PSYCHOTIC DISORDER, PERSONALITY DISORDER

Sensation: no problem numbness tingling weakness limited motion define area _____

Cardiovascular: heart rate regular heart rate irregular peripheral edema neck vein distention other ? HTN

Pulmonary: respiration easy and regular SOB Oxygen dependant breath sound clear other: _____

GI: Bowel sound: present absent Abdomen: soft distended firm other: _____
 constipation diarrhea needs nutritional consult UBH: 2x/day & Blood

GU: voids without difficulty incontinent other BPH TRANSGENER (M-F)

Reproductive: LMP NA Tubal Ligation Hysterectomy Menopause Birth Control _____
 Pregnancy Yes No Unknown

Skin: warm dry intact pink jaundice wounds rash breakdown _____

Pain: yes no severity 0 - 10 scale 2/10 abd Pain location/description/treatment ouch on @ neck
Procuris

Mobility: ambulate independent walker cane wheelchair total lift

Notes: COLON 2011 (EMEROL 25MG & VERSED 5MG) Hx Lyme Dx

Signature: Melissa Hauer MD **Date / Time:** 1/28/21 1045





BLAYK, BONZEEANNE R
 A00109611111 M000597460
 05/01/1956 64 F
 Lemberg, Brent D

C-1107

PATIENT STICKER

PROCEI
Intraprocedure (Service) Flow Sheet / Orders

Date: 1/28/21 See Unit Specific Record

*Sedation Start: 0 Recovery Start: 0
 *Procedure 1 Start: 1100 Stop: 1118
 *Procedure 2 Start: _____ Stop: _____

IV Access

Site: 1 Size: 24ga 22ga 20ga 18ga Saline Lock Preestablished IV Other: _____
 Solution: NS D5W D5W1/2NS LR Volume (mL) 1000 Rate KVO IV Start Time: _____ Initials: _____

White Scoring System	
Activity On Command	
2 = Able to Move All Extremities on Command	
1 = Some Weakness in Movement of Extremities	
0 = Unable to Voluntarily Move Extremities	
Respiration	
2 = Able to Breathe Deeply	
1 = Tachypneic with Good Cough	
0 = Dyspneic with Weak Cough	
Circulation - Systolic Blood Pressure	
2 = Within 20% of Pre-Operative/Pre-Procedure Level	
1 = Within 50 - 20% of Pre-Operative/Pre-Procedure Level	
0 = 50% or Less of Pre-Operative/Pre-Procedure Level	
Consciousness	
2 = Awake and Oriented	
1 = Arousable with Minimal Stimulation	
0 = Responsive Only with Tactile Stimulation	
Oxygen Saturation	
2 = SpO2 > 90% on Room Air	
1 = Supplemental O2 Required to Maintain SpO2 > 90%	
0 = SpO2 < 90% with Supplemental O2	
Post Op/Procedure Pain Assessment	
2 = None or Mild Discomfort	
1 = Moderate to Severe Pain Controlled with IV Analgesia	
0 = Persistent Severe Pain	
Post Op/Procedure Emetic Symptoms	
2 = None or Mild Nausea with No Active Vomiting	
1 = Transient Vomiting or Retching	
0 = Persistent Moderate-Severe Nausea and Vomiting	

Time	1050	1055	1100	1110	1120
PRESEDATION					
220					
200					
180					
160					
140					
120	✓	✓		✓	
100			✓		
80	^	^	^	^	^
60					
40					
20					
SPO2% / RR	97	96	95	98	97
ETCO2	37	37	37	37	37
Temperature	98.0				

POC Urine Pregnancy Test
 Results: _____

Assessments:	White Score
Cardiac:	Activity
C = chest pain	Respiration Rate
R = rhythm change	Circulation
N = normal rhythm	Consciousness
Abdominal Assessment:	O2 Saturation
S = soft	Pain Assessment
D = distended	Emetic Symptoms
F = firm	Total
Skin Assessment:	
D = diaphoretic	Fentanyl mcgs IV
C = cyanotic	Midazolam mgs IV
W = warm & dry	Meperidine mgs IV
Treatment:	Flumazenil mgs IV
Patient position:	Naloxone mgs IV
S = supine	Oxygen via
P = prone	Antibiotic IV:
R = right lateral	
L = left lateral	
Comfort & Safety:	Initials:
P = physical comfort	Cardiac
E = emotional	Abdomen
S = safety/environmental	Skin
A = airway suctioned	Pt position
	Comfort/safety
	Bite Block
Bite Block	Comments:
I = inserted	
R = removed	

RN Signature: / Initials Melissa Hayes MS Date / Time: 1/28/21 1045 RN Signature: / Initials _____ Date / Time: 1/28/21

Orders
 Provider Signature: [Signature] 1-28-21 Date/Time: _____

1100



Date: 1/28/21

Boston Scientific
Radial Jaw™ 4
3.2mm
GTIN 08714729745624
REF M00513370
LOT 25778791



BLAYK, BONZEAANNE R
A00109611111 M000597460
05/01/1956 64 F
Lemberg, Brent D

Intra procedure (service) Flow Sheet/Orders (cont).

All patients who receive Procedural Sedation are considered high risk for falls. Assistance is required.

KEY: BP ∇ Pulse \bullet

STERIS

REF 00711115

UDI (01)00724995182618



(17) 2023-10-13

(11) 2020-10-13

(10) 2010101 LOT

Baseline BP: 121/99 See Additional Page See Unit Specific Record

Time											Comments
220											PT IV LAC unable to thread. pt refused end attempt. pt requesting no sedation. pt not aware of IV placement - MA
200											
180											
160											
140											
120											
100											
80											
60											
40											
20											
SPO2% / RR											
ETCO2											<input type="checkbox"/> ETCO ₂ Precluded by Nature of Procedure
Temperature											
											White Score
											Activity
											Respiration Rate
											Circulation
											Consciousness
											O2 Saturation
											Pain Assessment
											Emetic Symptoms
											Total
											Medications
											Fentanyl mcgs IV
											Midazolam mgs IV
											Meperidine mgs IV
											Flumazenil mgs IV
											Naloxone mgs IV
											Oxygen via
											Antibiotic IV:
											Initials
											Cardiac
											Abdomen
											Skin
											Pt Position
											Comfort/Safety
											Bite Block

Input PO Fluids	Total	IV Solution	Total	Output Urine/Other
0		LR	300	
RN Signature: <u>Melinda Hous</u> Date: <u>1/28/21</u> Time: <u>1125</u> Initials: <u>MH</u>				

Medication Waste
Midazolam 0 mg
Fentanyl 0 mcg
Meperidine 0 mg
Other _____



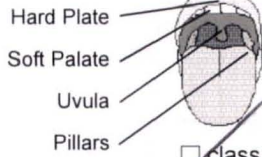


PRE-PROCEDURE (Service)

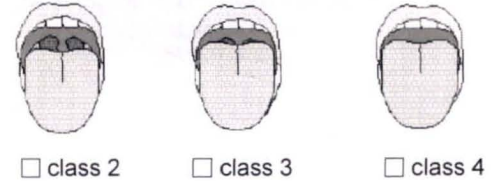
Provider Focused Physical Assessment

ASA Classification

- Class I: Normal/Healthy
- Class II: Mild systemic disease
- Class III: Severe systemic disease
- Class IV: Severe systemic disease/constant threat to health
- Class V: Not expected to survive with or without procedure



Mallampati airway classification



SEE H&P (completed at time of procedure - includes heart and lung assesment)

Cleared for moderate sedation: Yes No

Diagnosis: _____

Heart: _____ Lungs: _____

Comment/plan of care: _____

By signing this document I attest to have personally reviewed and agree with the Pre-Sedation History and

Pre-Service Assessment update: No Sedation

Provider Signature _____ Date / Time: 1-28-21

Provider Post-Procedure (Service) Note

See Unit Specific Record (no signature required)

Pre-Procedural Diagnosis: _____

Post-Procedural Diagnosis: _____

Procedure: _____

Estimated Blood Loss: None _____

Specimen(s): None _____

Findings: N/A _____

Implants/Tubes/Drains Placed: None _____

Provider Signature _____ Date / Time: 1-28-21

Discharge/Follow-Up

Discharge to home ≥ 13 Discharge to unit ≥ 11

IV D/C by _____ @ _____ IV Site _____ Clean Swelling Tenderness Redness

Meets Criteria: Yes No; if no was provider notified? Yes No

- Yes No Post procedure instructions given.
- Yes No Patient and family state comfortable with discharge plan
- Yes No NA Post procedure teaching given *Dr. Lemberg 1120*
- Yes No NA Tolerating PO minimal nausea
- Yes No NA Ambulating with steady gait
- Yes No NA Voiding without difficulty
- Yes No NA Drainage from incision normal

Discharge To: Home Inpatient room # _____ ED Other: _____

D/C via: Ambulatory Wheelchair Bed Stretcher

Accompanied by: Relative Friend Other: *independent*

Report to: _____ @ _____

Discharge Time: *1130* Discharge Nurse: *M. Haws*

RN Signature	Date	Time	Initials
<i>Melissa Haws</i>	<i>1/28/21</i>	<i>1130</i>	<i>mh</i>
<i>M. Haws</i>	<i>1/28/21</i>	<i>013</i>	<i>mh</i>

Follow up phone call: Date: *later* Time: *013* By: *Melissa*

Number of attempts: *1* Result: No Answer Wrong Number

See Unit Specific

Message left on machine Contacted patient/family member

- | | | | | | |
|-------------------------------------|--------------------------|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Yes | No | NA | Yes | No | NA |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Were you satisfied with your experience?

Instructed Patient to call Physician concerning _____

Comments: _____

